Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEXAS HEALTH DBA INJURY 1-DALLAS
9330 LBJ FREEWAY SUITE 1000
DALLAS TX 75243

Carrier's Austin Representative Box
Box Number 19

Respondent Name
INSURANCE CO OF THE STATE OF PA

MFDR Date Received
AUGUST 27, 2010

MFDR Tracking Number
M4-10-5294-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Enclosed are copies of the preauthorization letter, EOBs, claims, and documentation. The patient was referred for the Chronic Pain Management Program. The services were provided and the claims were denied per EOB unnecessary medical treatment based on peer review. CPT code 97799 CPCA was preauthorized, **#4237789** therefore it is deemed medically necessary… Per **DWC Rule 133.301(a)**, the insurance carrier shall not retrospectively review the medical necessity of a medical bill for treatment(s) and/or services(s) for which the medical care provider has obtained preauthorization under Rule 134.600(h). In summary, it is our position that Broadspire Insurance has established an unfair and unreasonable time frame in paying for the services that were medically necessary and rendered…"

Amount in Dispute: $937.50

On October 18, 2010, the Division received written notification from the requestor's representative, Judith Guerra, via email stating that the only date of service that remains unpaid and in dispute is February 26, 2010.

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier asserts that it has paid according to applicable fee guidelines and/or reduced to fair and reasonable. Further, the carrier challenges whether the charges are consistent with applicable fee guidelines. All reductions of the disputed charges were made appropriately."

Response Submitted by: Flahive, Ogden & Latson P. O. Drawer 13367, Austin, TX 78711

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 26, 2010	Chronic Pain Management Program CPT Code 97799-CP-CA (7.5 hours)	$937.50	$937.50

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Tex. Administrative Code §134.600 sets out guidelines for preauthorization, concurrent review, and voluntary certification of health care.
3. 28 Texas Administrative Code §134.204 sets out medical fee guidelines for workers' compensation specific services provided on or after March 1, 2008.
4. 28 Texas Administrative Code §133.240 sets out the procedures for medical payments and denials.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated March 11, 2010
   - 080-001 – REVIEW OF THIS BILL HAS RESULTED IN AN ADJUSTED REIMBURSEMENT FOR THE ENTIRE BILL OF $0.00
   - 111-001 – COVENTRY CONTRACT STATUS INDICATOR 01 – CONTRACTED PROVIDER
   - 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).
   - 910-051 – UNNECESSSARY TREATMENT BASED ON PEER REVIEW.
   - W1 – Workers Compensation State Fee Schedule Adjustment.
   - W9 – Unnecessary medical treatment based on peer review.
   - BILL NOTES: Coventry Message – EPFH – The charges have been priced in accordance to a First Health owned contract. For questions, Please Call 1-800-937-6824.
   - 900 – BASED ON FURTHER REVIEW, NO ADDITIONAL ALLOWANCE IS WARRANTED.
   - BILL NOTES: Coventry Message – EPFH – The charges have been priced in accordance to a First Health owned contract. For questions, Please Call 1-800-937-6824.

Issues

1. Were the disputed services subject to a specific fee schedule set in a contract between the parties that complies with the requirements of Labor Code §413.011?
2. Did the requestor file for medical fee dispute resolution in accordance with 28 Texas Administrative Code §133.240?
3. Did the requestor obtain preauthorization approval prior to providing the chronic pain management program in dispute in accordance with 28 Texas Administrative Code §134.600?
4. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier reduced or denied disputed services with reasons "111-001 – COVENTRY CONTRACT STATUS INDICATOR 01 – CONTRACTED PROVIDER"; and "45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement." Review of the submitted information finds insufficient documentation to support that the disputed services are subject to a contractual agreement between the parties to this dispute. The above denial/reduction reasons are not supported. Therefore the disputed services will be reviewed per the applicable Division rules and fee guidelines.
2. 28 Texas Administrative Code, Section §133.240(b) states, "For health care provided to injured employees not subject to a workers' compensation health care network established under Insurance code Chapter 1305, the insurance carrier shall not deny reimbursement based on medical necessity for health care preauthorized or voluntarily certified under Chapter 134 of the title (relating to Benefits—Guidelines for Medical Services, Charges, and Payments." 28 Texas Administrative Code, Section §134.600(c)(1)(B) states, "The carrier is liable for all reasonable and necessary medical costs relating to the health care required to treat a compensable injury…only when the following situations occur…preauthorization of any heath health care listed in subsection (p) of this section was approved prior to providing the health care." 28 Texas Administrative Code, Section §134.600(p)(10) requires preauthorization of "chronic pain management/interdisciplinary pain rehabilitation." Review of the submitted preauthorization letter dated January 29, 2010 supports the Chronic Pain Management Program for 10 day initial trial, was approved with a start date of January 29, 2010 and an end date of

March 16, 2010r. Review of the submitted preauthorization letter dated February 17, 2010 supports the Chronic Pain Management Program for 10 additional days, was approved with a start date of February 17, 2010 and an end date of April 3, 2010, which includes the disputed date of service. Therefore the disputed services will be reviewed per the applicable Division rules and fee guidelines.

3. 28 Texas Administrative Code §134.600(p)(10) requires preauthorization of "chronic pain management/interdisciplinary pain rehabilitation." Review of the submitted preauthorization letter dated January 29, 2010 supports the Chronic Pain Management Program for 10 day initial trial, was approved with a start date of January 29, 2010 and an end date of March 16, 2010. Review of the submitted preauthorization letter dated February 17, 2010 supports the Chronic Pain Management Program for 10 additional days, was approved with a start date of February 17, 2010 and an end date of April 3, 2010, which includes the disputed date of service. The requestor has supported their position that the disputed chronic pain management program was preauthorized per 28 Texas Administrative Code, Section §134.600; therefore, the requestor is entitled to reimbursement as follows per 28 Texas Administrative Code, Section §134.204.
4. Per 28 Texas Administrative Code §134.204(h)(5)(B), states "Reimbursement shall be $125.00 per hour. Units of less than one hour shall be prorated in 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes." A CARF accredited program is indicated by using the modifier –CA. Review of the submitted documentation finds that based on the factual determination that the provider did bill the disputed services with the –CA modifier, therefore, the monetary value of the program will be 100% of the CARF accredited value.

   DOS February 26, 2010: $125.00 x 7.5 hours = $937.50. IC Paid $0.00. Due: $937.50

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $937.50.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $937.50 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 19, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.